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Agency of Human Services

MEMORANDUM

To: Representative Bill Lippert, Chair, House Committee on Healthcare
From: Steven M. Costantino, Commissioner, Department of Vermont Health Access
Cc: Hal Cohen, Secretary, Agency of Human Services
Date: February 24, 2016
Re: Request for Information Following Testimony on the SFY 2017 DVHA Budget

During the Department of Vermont Health Access (DVHA) SFY 2017 budget testimony on Wednesday, February 17, you requested additional information with regard to the SFY 2017 DVHA budget. Below are the questions posed and DVHA's responses.

Could you please advise as to how other states manage their Medicaid programs? **MEDICAID:** Administrative costs of Medicaid are typically less than 7 percent, or half the rate that's typically seen in the private sector (per administrative costs reported to CMS for federal fiscal year 2014). Additionally it should be noted that percent comparisons are not necessarily an apples-to-apples view due to the effects of the cost shift (the denominator when performing the calculation is lower in Medicaid than private insurance). Within the Medicaid program, costs must be classified as a "program/service" or "administrative"$_2$. The Centers for Medicare and Medicaid Services (CMS) recognize that state Medicaid programs rely on administrative activities that extend beyond the provision of direct services to clients. States are responsible for locating, coordinating, and monitoring necessary and appropriate services for each Medicaid recipient. Additionally, states must identify and enroll individuals before they can access services. Because the cost of these activities is often more difficult to quantify than direct service costs, there will be state to state variations on what activities are claimed "administrative" for federal participation. Some states are more centralized: in those states it can be easier to quantify if all administrative costs as they run through a single state Medicaid agency.

The majority of Medicaid States contract with Managed Care Organizations, MCOs to help reduce overall program costs. The total administrative costs for operating MCOs have been a source of difficulty for many states and there is a significant degree of variability in the admin portion of the MCO PMPM. The actuarial methods used to set the PMPM vary as well. DVHA operates as a publicly operated managed care organization. Therefore, like some other states, the operating expenses for the Global Commitment Waiver appear as programmatic expenses as reported to CMS.

Areas in which states may expend admin dollars are:

MMIS ~15% of total Admin
General Administration: payroll services and fringe benefits, overhead ~81% of total Admin
Fraud & Abuse: ~1.6% of total admin
Survey & Certification: ~2.6% of total admin

- Medicaid Outreach
- Medicaid Eligibility Determinations
- Referrals to Service
- Case Planning
- Case Management
- Development of an Individual Plan of Care

- Case Reviews

For some of these items, Vermont processes these as program targeted case management costs and not administrative costs. Attached please find the most recently reported federal fiscal year (2014) administrative Medicaid costs as reported to CMS by each state.[3] (Vermont reported under 3% administrative costs in FFY 2014.)

MEDICARE: The Centers for Medicare and Medicaid Services (CMS) annually publishes two measures of Medicare's administrative expenditures. One of these appears in the reports of the Medicare Boards of Trustees and the other in the National Health Expenditure Accounts (NHEA). The latest trustees' report indicates Medicare's administrative expenditures are 1 percent of total Medicare spending, while the latest NHEA indicates the figure is 6 percent. The debate about Medicare's administrative expenditures reflects widespread confusion about the data and the methodology used by CMS to calculate. Critics of Medicare argue that the official reports on Medicare's overhead may not take into consideration some types of administrative spending, such as the cost of collecting taxes and Part B premiums. Regardless, the administrative costs for Medicare are considerably lower than private insurers.

PRIVATE INSURANCE: Many insurance companies spend a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing. The Affordable Care Act requires insurance companies to spend at least 80% or 85% of premium dollars on medical. That means that between 15% and 20% may be used on administrative costs and profits - much higher than State Medicaid Agencies and Medicare.

Sources:

1. https://www.linkedin.com/cws/share?token&isFramed=false&url=http%3A%2F%2Fwp.me%2FpvY1d-5ou
2. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/medicaid-administrative-claiming.html
3. https://www.macpac.gov/publication/medicaid-spending-by-state-category-and-source-of-funds/

Who is the hiring authority for exempt positions? The Governor directly appoints the Commissioner. All other exempt hires are at the discretion of the Commissioner.

Would it be possible to get an AHS org chart that specifically identifies how policy positions are managed? Please see the attached organizational chart, provided by Sarah Clark, AHS Chief Financial Officer.

Who is the Exchange Project Director that reports directly to the Deputy Commissioner for Fiscal & Support Services? What is the Health Reform Enterprise Unit Could you provide an organizational chart with names and work locations? The Exchange Project Director is Tena Perelli. She oversees and manages the call center contract and works on an agency-wide team to develop best practices related to customer service (which will be the business requirements in a new customer service RFP). The Health Reform Enterprise Director leads the MMIS Unit. This team of individuals is working on the MMIS project which is described on page 52. Please see the new organizational chart attached.

CMS -64 Medicaid Spending by State, Category, and Source of Funds, FY 2014 (millions)

	Benefits			State program administration			Total Medicaid			State program administration %			
State[1]	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Gross Admin Rank
Northern Mariana Islands	$34	$19	$14	$1	$0	$0	$34	$20	$14	1.48%	1.81%	1.03%	1
Kentucky	$7,793	$5,935	$1,858	$223	$157	$66	$8,016	$6,092	$1,924	2.78%	2.58%	3.41%	2
Vermont	$1,526	$901	$625	$44	$39	$5	$1,570	$940	$630	2.80%	4.11%	0.84%	3
Arizona	$9,185	$6,565	$2,620	$268	$195	$73	$9,453	$6,760	$2,693	2.83%	2.88%	2.72%	4
Mississippi	$4,865	$3,585	$1,280	$151	$102	$49	$5,016	$3,687	$1,330	3.01%	2.76%	3.70%	5
American Samoa	$25	$14	$11	$1	$0	$0	$26	$15	$11	3.22%	3.28%	3.15%	6
New York	$51,806	$27,622	$24,184	$1,792	$1,074	$719	$53,599	$28,696	$24,903	3.34%	3.74%	2.89%	7
Florida	$20,303	$12,151	$8,152	$747	$471	$276	$21,050	$12,623	$8,428	3.55%	3.73%	3.27%	8
Louisiana	$7,056	$4,408	$2,647	$282	$177	$105	$7,338	$4,586	$2,752	3.85%	3.87%	3.81%	9
Ohio	$19,439	$13,068	$6,371	$784	$502	$282	$20,223	$13,570	$6,653	3.88%	3.70%	4.23%	10
Pennsylvania	$23,462	$12,705	$10,757	$953	$602	$351	$24,415	$13,306	$11,109	3.90%	4.52%	3.16%	11
Alabama	$5,213	$3,599	$1,614	$212	$136	$76	$5,425	$3,735	$1,690	3.91%	3.64%	4.52%	12
New Mexico	$4,169	$3,140	$1,029	$180	$121	$59	$4,349	$3,261	$1,088	4.15%	3.71%	5.44%	13
Maryland	$9,210	$5,255	$3,955	$415	$268	$147	$9,626	$5,523	$4,102	4.32%	4.86%	3.59%	14
Texas	$31,385	$18,790	$12,595	$1,446	$884	$562	$32,831	$19,674	$13,157	4.40%	4.49%	4.27%	15
Missouri	$8,829	$5,545	$3,284	$410	$271	$139	$9,239	$5,816	$3,423	4.44%	4.66%	4.06%	16
West Virginia	$3,331	$2,454	$877	$157	$105	$52	$3,488	$2,559	$929	4.51%	4.11%	5.61%	17
Puerto Rico	$1,842	$1,139	$703	$87	$62	$26	$1,929	$1,201	$728	4.54%	5.13%	3.55%	18
Michigan	$13,503	$9,270	$4,233	$645	$439	$206	$14,148	$9,709	$4,439	4.56%	4.52%	4.65%	19
Iowa	$3,922	$2,460	$1,462	$189	$137	$51	$4,110	$2,597	$1,513	4.59%	5.29%	3.38%	20
Tennessee	$9,205	$6,064	$3,141	$449	$282	$167	$9,654	$6,346	$3,308	4.65%	4.44%	5.06%	21
Georgia	$9,397	$6,347	$3,050	$461	$312	$150	$9,858	$6,659	$3,199	4.68%	4.68%	4.67%	22
Massachusetts	$14,251	$7,321	$6,929	$702	$422	$280	$14,952	$7,743	$7,209	4.69%	5.45%	3.88%	23
Connecticut	$6,821	$3,879	$2,942	$347	$215	$132	$7,168	$4,094	$3,074	4.85%	5.25%	4.30%	24
Hawaii	$1,950	$1,125	$824	$100	$76	$24	$2,050	$1,201	$848	4.87%	6.33%	2.81%	25
South Carolina	$5,321	$3,771	$1,550	$276	$185	$90	$5,597	$3,956	$1,640	4.92%	4.69%	5.49%	26
Wisconsin	$7,396	$4,448	$2,949	$387	$241	$146	$7,783	$4,689	$3,094	4.97%	5.14%	4.71%	27
Rhode Island	$2,437	$1,410	$1,027	$129	$88	$42	$2,566	$1,498	$1,069	5.04%	5.87%	3.89%	28
North Carolina	$11,993	$7,945	$4,047	$663	$440	$222	$12,655	$8,386	$4,269	5.24%	5.25%	5.20%	29
Oklahoma	$4,666	$3,038	$1,629	$259	$178	$81	$4,925	$3,215	$1,710	5.26%	5.52%	4.76%	30
Indiana	$9,094	$6,145	$2,949	$506	$324	$182	$9,600	$6,469	$3,131	5.27%	5.01%	5.80%	31
Virginia	$7,547	$3,843	$3,704	$433	$299	$134	$7,980	$4,142	$3,838	5.42%	7.21%	3.49%	32
New Jersey	$12,470	$7,099	$5,371	$724	$408	$316	$13,194	$7,507	$5,687	5.48%	5.43%	5.55%	33

Washington	$10,250	$6,434	$3,816	$596	$361	$235	$10,846		$6,794		$4,051	5.49%	5.31%	5.81%	34
Colorado	$5,919	$3,335	$2,584	$346	$224	$122	$6,265		$3,559		$2,706	5.52%	6.29%	4.51%	35
Minnesota	$9,918	$5,481	$4,437	$595	$370	$225	$10,513		$5,851		$4,663	5.66%	6.33%	4.83%	36
Guam	$74	$42	$32	$5	$3	$1	$78		$45		$33	5.93%	7.14%	4.28%	37
Arkansas	$4,840	$3,615	$1,225	$314	$211	$104	$5,154		$3,826		$1,328	6.10%	5.51%	7.80%	38
Nevada	$2,281	$1,589	$692	$151	$109	$42	$2,432		$1,698		$734	6.20%	6.43%	5.67%	39
District of Columbia	$2,368	$1,721	$647	$157	$100	$57	$2,524		$1,821		$704	6.21%	5.50%	8.04%	40
Illinois	$16,616	$8,940	$7,676	$1,106	$669	$438	$17,723		$9,609		$8,114	6.24%	6.96%	5.40%	41
Delaware	$1,692	$1,004	$688	$113	$80	$33	$1,805		$1,084		$721	6.28%	7.38%	4.63%	42
Idaho	$1,586	$1,137	$448	$107	$77	$30	$1,692		$1,214		$478	6.31%	6.33%	6.25%	43
Montana	$1,072	$729	$343	$72	$52	$21	$1,145		$781		$363	6.33%	6.65%	5.64%	44
Maine	$2,365	$1,471	$895	$163	$117	$47	$2,529		$1,587		$941	6.46%	7.35%	4.96%	45
New Hampshire	$1,323	$678	$645	$98	$66	$32	$1,421		$744		$677	6.90%	8.83%	4.78%	46
Oregon	$6,784	$4,952	$1,832	$507	$281	$226	$7,291		$5,233		$2,058	6.95%	5.37%	10.98%	47
Kansas	$2,728	$1,562	$1,165	$205	$136	$69	$2,933		$1,699		$1,234	6.99%	8.01%	5.59%	48
Nebraska	$1,772	$979	$793	$136	$91	$45	$1,907		$1,070		$838	7.11%	8.46%	5.38%	49
California	$63,384	$35,756	$27,628	$4,864	$2,724	$2,140	$68,248		$38,480		$29,769	7.13%	7.08%	7.19%	50
South Dakota	$778	$455	$323	$63	$42	$21	$841		$497		$344	7.46%	8.46%	6.02%	51
Utah	$2,064	$1,459	$606	$170	$124	$46	$2,235		$1,583		$652	7.62%	7.83%	7.09%	52
Alaska	$1,412	$832	$580	$134	$85	$50	$1,547		$917		$630	8.67%	9.23%	7.86%	53
Wyoming	$539	$276	$263	$55	$37	$18	$595		$313		$281	9.27%	11.82%	6.44%	54
North Dakota	$402	$206	$195	$49	$32	$17	$451		$239		$212	10.91%	13.57%	7.92%	55
Virgin Islands	$71	$40	$31	$9	$8	$1	$80		$47		$32	11.23%	16.18%	3.98%	56

Notes: FY is fiscal year. Total federal spending shown here ($302,954 million) will differ from total federal outlays shown in FY 2016 budget documents due to slight
– Dash indicates zero; $0 indicates an amount less than $0.5 million that rounds to zero.

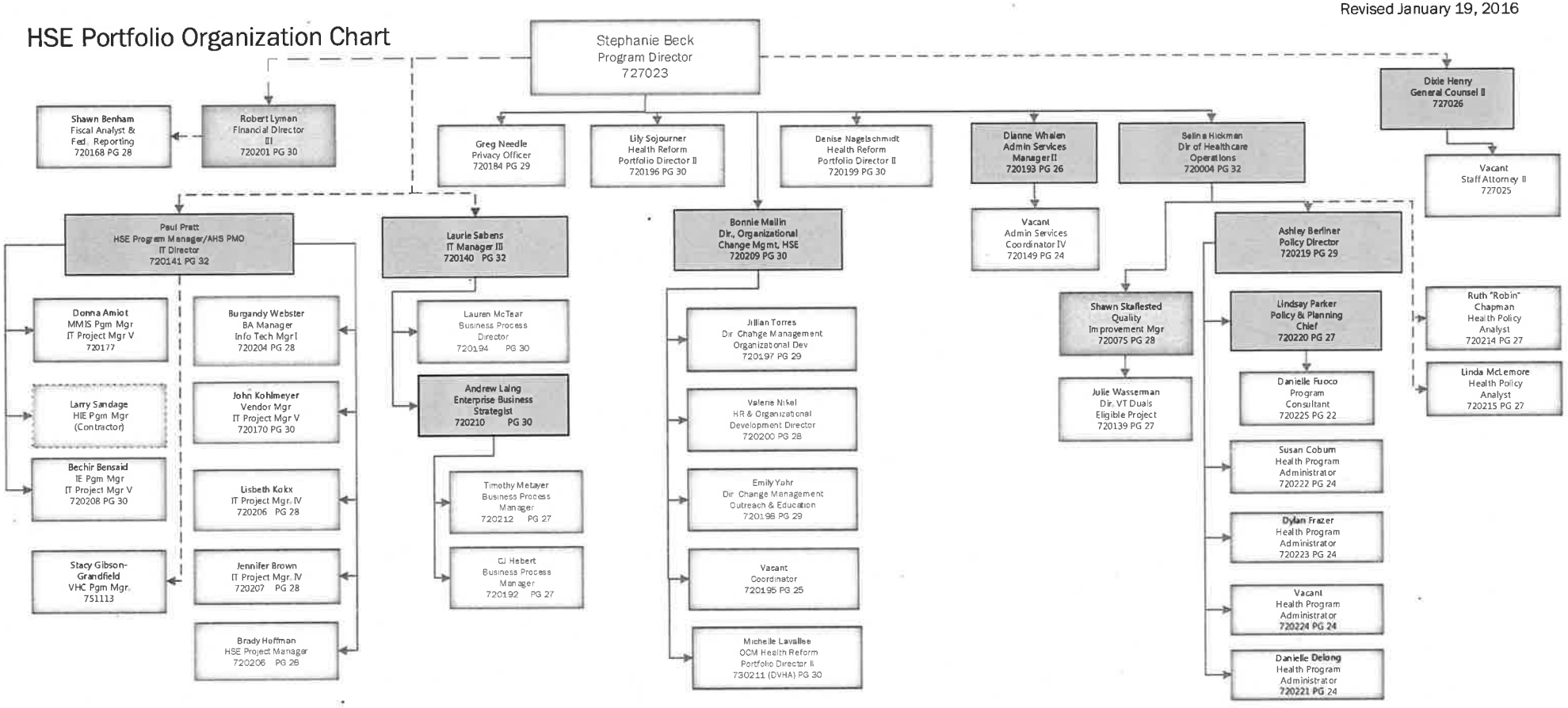
[1] Not all states have certified their CMS-64 FMR submissions as of February 25, 2015. California's and Colorado's second, third, and fourth quarter submissions are not certified; North Dakota's third and fourth quarter submissions are not certified; South Carolina's second quarter submission is not certified; Rhode Island's fourth quarter submission is not certified. Figures presented in this exhibit may change if states revise their expenditure data after this date.

Sources: For state and territory spending: MACPAC, 2015, analysis of CMS-64 FMR net expenditure data as of February 25, 2015. For all other spending (MCFUs, survey and certification, VFC): Centers for Medicare & Medicaid Services, 2015, *Fiscal year 2016 justification of estimates for Appropriations Committees*, Baltimore, MD, http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf.

https://www.macpac.gov/publication/medicaid-spending-by-state-category-and-source-of-funds/

Revised January 19, 2016

HSE Portfolio Organization Chart



Execution

(See detail on page 2)

- Managing the schedule of the portfolio and subsequent programs and projects
- Communication of the health and progress of all aspects of the portfolio
- Risk Management
- Project resource management

Enterprise Business Strategy

1. Develop strategies and Business Architecture
2. Model the business domain as a collection of business capabilities and business processes
3. Document and maintain the relationships between business entities
4. Utilize business capability needs as input to ongoing enterprise project/program integrated plan.
5. Perform ongoing analysis of the business capability model
6. Escalate issues and risks that arise from Business Architecture processes through PMO governance processes.
7. Serve as interface between SoV Business, Enterprise Architecture, Business Analysis and AHS IT teams.

Organizational Change

- Address speed of adoption & Utilization of new systems/processes
- Help project sponsors in supporting change
- Foster alignment within project team
- Coordinate communication activities to support change adoption
- Support and coach supervisors
- Advance workforce transition and organizational design to meet business needs
- Reinforce business outcomes of change efforts

Health Care Operations

- Federal Partner relationship management - Medicaid waiver
- AHS-wide quality improvement
- AHS health care compliance issues
- Health care operations consultation for AHS statewide Medicaid Policy:
- Provides assistance and guidance to AHS departments related to Medicaid program initiatives and policy development.
- Takes a point role in deployment of initiatives requiring adoption as a result of legislation and assists with problem solving, facilitation, and coordination of programmatic changes.